DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: VD6X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00022

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245285**

2.STATE VENDOR OR MEDICAID NO.
(L2) **659561800**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS**
(L4) **1301 50TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (L6) **55077**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/30/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Mary Heim, HPR Social Work Specialist 09/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/19/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
08/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 10/27/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/21/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245285
October 19, 2015

Ms. Pamela Schultz, Administrator
Good Samaritan Society - Inver Grove Heights
1301 50th Street East
Inver Grove Heights, Minnesota 55077

Dear Ms. Schultz:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 22, 2015 the above facility is certified for or recommended for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 19, 2015

Ms. Pamela Schultz, Administrator
Good Samaritan Society - Inver Grove Heights
1301 50th Street East
Inver Grove Heights, Minnesota 55077

Re: Reinspection Results

Dear Ms. Schultz:

On September 30, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 10, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245285	A. Building B. Wing	9/30/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0314 Reg. # 483.25(c) LSC	09/22/2015	ID Prefix F0329 Reg. # 483.25(l) LSC	09/22/2015	ID Prefix F0428 Reg. # 483.60(c) LSC	09/22/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/KJ	10/19/2015	30922	09/30/2015
CMS RO				

Followup to Survey Completed on: 8/13/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

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(L4) **1301 50TH STREET EAST**
(L5) **INVER GROVE HEIGHTS, MN** (L6) **55077**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/13/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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FISCAL YEAR ENDING DATE: (L35)
12/31

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Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Mary Heim, HPR Social Work Specialist 09/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 09/18/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

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3. Both of the Above :
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08/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 09/21/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 25, 2015

Ms. Pamela Schultz, Administrator
Good Samaritan Society - Inver Grove Heights
1301 50th Street East
Inver Grove Heights, Minnesota 55077

RE: Project Number S5285024

Dear Ms. Schultz:

On August 13, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 22, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 13, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 13, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Received 9/11/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a system for consistent, accurate monitoring of pressure ulcers for 2 of 3 residents reviewed, (R48, R62). Findings include: The facility failed to ensure a system for	F 314		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Ronald Klumb Administrator Sept 8, 2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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F 314	Continued From page 1 consistent, accurate monitoring of multiple pressure ulcers for R48. In addition, monitoring and documentation was not consistent with the findings of wound clinic registered nurse and physician assessment. Sacrum: Review of R48's discharge paperwork from the hospital, dated 5/18/15, noted a suspected deep tissue injury on the right buttock. (Suspected deep tissue injury -Localized area of discolored (darker than surrounding tissue) intact skin or blood-filled blister related to damage of underlying soft tissue from pressure and/or shear. Area of discoloration may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.) A referral form from a wound clinic registered nurse, dated 5/26/15, noted an unstageable ulcer on the right sacrum. (Unstageable Pressure Ulcer- not stageable due to non-removable dressing/device or due to the coverage of the wound bed by slough or eschar.) Wound RN [Registered Nurse] Assessment forms, dated 5/20/15 revealed R48 was admitted to the facility with a healing stage I ulcer on the sacrum. (Stage I pressure ulcer: a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.) The Wound RN Assessment form, dated 5/21/15 noted a healing stage I ulcer. On 5/27/15 the Wound RN Assessment form noted a stage III ulcer on the sacrum. (Stage III - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough	F 314	The facility immediately reviewed the assessments and documentation for R48 and R62. R62's pressure ulcer was reassessed by DNS and accurate documentation was ensured. R48 had been a discharged resident review therefore no assessment and changes to reflect accurate documentation could be made. The facility will review all documented pressure ulcers for assessment and documentation accuracy and correct as needed. The policy and procedure for assessing and documenting pressure ulcers was reviewed.	9/30/15

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F 314	Continued From page 2 may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) There were no further Wound RN Assessments of the sacrum and R48 discharged on 6/18/15. Right Gluteal Fold: Review of R48's,Wound RN Assessment form, dated 5/20 noted an unstageable ulcer on the right gluteal fold. The Wound RN Assessment forms, dated 5/21/15 noted a stage 3 pressure ulcer on the right gluteal fold. On the 6/2/15 and 6/9/15 Wound RN Assessment forms noted an unstageable ulcer was on the right gluteal fold. No further Wound RN Assessments were noted and R48 discharged on 6/18/15. Right Heel: Review of R48's, Discharge paperwork from the hospital, dated 5/18/15, noted a stage II pressure ulcer on the right heel. A referral form from a wound clinic registered nurse, dated 5/26/15, noted a stage II ulcer with a self absorbed blister on the right heel. (Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister.) Wound RN [Registered Nurse] Assessment forms, dated 5/20/15 and 5/21/15 noted R48 was admitted with an ulcer on the right heel which was	F 314	The facility will re-educate licensed nursing staff on the procedure for assessments and documentation of pressure ulcers with the focus on accuracy and consistency; and will re-educate licensed nursing staff on how to utilize specialty wound clinicians and physician findings of assessed pressure ulcers to maintain accurate and consistent documentation.	

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F 314	Continued From page 3 noted as "not staged." On 6/2/15 and 6/12/15 the Wound RN Assessment forms note an unstageable ulcer which healed on 6/16/15. Wound Data Collection forms, dated 5/20/15 through 6/15/15 consistently note the wound bed is primarily eschar (up to 90%) until healed on 6/16/15. The wound bed was noted to be 80% eschar on the same day the wound clinic registered nurse and physician assessed the right heel ulcer to be a stage II pressure ulcer. A stage II pressure ulcer would not have eschar present. Left Heel: On 6/9/15 the Wound RN Assessment forms noted an unstageable ulcer on R48's left heel. There were no further assessments of the left heel wound. On 8/12/15 at 1:42 p.m. the director of nursing explained that after reviewing all wound documentation she was able to determine R48 was admitted with a stage II ulcer, presenting as a right heel blister that healed on 6/16/15. DON reported the left heel wound which was documented on 6/9/15 was in error and should have been noted as the right heel. DON further explained R48 was admitted with a reddened spot near her sacrum which healed on 5/21/15 and an unstageable ulcer near her right gluteal fold. DON explained the various nurses who completed weekly RN Wound Assessments and almost daily Wound Data collections interchangeably labeled the pressure ulcer as located on the right gluteal fold and sacrum before consistently documenting the wound as located on the right gluteal fold after 5/31/15.	F 314	The unit managers and/or designee[s] will monitor through audits, for consistent and accurate assessment and documentation of pressure ulcers. The facility will review audit reports at the monthly QAPI meetings to ensure ongoing compliance. The DNS, ADON, and/or designee[s] will be responsible for overall monitoring. The DNS is responsible for overall compliance.	

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F 314	Continued From page 4 DON confirmed the wound clinic registered nurse and physician assessed the wound as located on the right sacrum. DON confirmed the documentation was "confusing" as it was not consistent or accurately describing the stage of the wounds, location and types of tissue on the wound bed. DON reported the licensed nursing staff were trained in pressure ulcer assessment but planned to now provide further training. R62 did not receive consistent and accurate monitoring of an unstageable pressure ulcer. Record review revealed a Wound RN Assessment form, dated 7/1/15, describing a "new area of pressure," stage 1 pressure ulcer to the coccyx (tail bone area). A Wound Data Collection form, dated 7/1/15, showed the wound measured 2.3 cm [centimeter] long x 1.2 cm wide x 0.1 cm deep. There were no measurements documented on the wound again until 7/16/15, when a Wound Data Collection form described the wound as a "scaral pressure ulcer" [sic] measuring 2 cm x 0.2 cm x 0.1. This form also described the wound as 80% eschar (necrotic tissue that appears black, brown, or tan). A Wound RN Assessment, dated 7/16/15, listed the wound as a "sacral pressure ulcer" that was unstageable. The next Wound RN Assessment, dated 7/18/15, listed the wound as a stage 2 pressure ulcer to the sacrum (triangular shaped bone at the base of the spine). A Wound Data Collection form, dated 7/22/15, contained the wound measurements of 2.5 cm x 1.6 cm x 0.1 cm, and the description of 95% eschar. The 7/25/15 Wound RN Assessment form listed the wound as an unstageable pressure ulcer to the coccyx, the 8/1/15 Wound RN Assessment listed	F 314		

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F 314	Continued From page 5 the wound as a stage one pressure ulcer to the coccyx, and the 8/8/15 Wound RN Assessment showed a pressure ulcer to the coccyx, with no staging listed. That was the last Wound RN Assessment found in the record for this wound. Wound measurement documentation continued, at least weekly, on Wound Data Collection forms, with the most recent done on 8/10/15, and listing the measurements of a wound to the coccyx as 2.3 cm x 1.7 cm x 0.1 cm. When interviewed on 8/13/15, at 1:13 p.m., regarding R62's wound, the director of nursing provided copies of the assessment and monitoring documentation of the wound. She was asked if there was any other documentation regarding the assessment and monitoring of this wound and she replied that she had provided all that documentation, and stated that she believed that the facility had an excellent system in place for assessing and monitoring pressure ulcers, but the implementation of that system may not be perfect. She acknowledged that she had noticed that some nurses described the location of the wound in different areas and some nurses staged the wound differently. When asked if there was a designated wound nurse in the facility, she replied that all nurses in the facility are expected to be able to assess a pressure ulcer. The Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements policy, revised 5/2015, directed staff "When a pressure ulcer is present, daily monitoring (with accompanying documentation when a complication or change is identified) should include the following: an evaluation of the the ulcer, if no dressing is present; an evaluation of the status of the dressing if present (whether it is intact and	F 314		

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F 314	Continued From page 6 whether draining, if present, is or is not leaking)' the status of the area surrounding the ulcer (that can be observed without removing the dressing); the presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection (for example, increased redness or swelling around the wound or increased drainage from the wound); whether pain, if present, is being adequately controlled" The policy further directed staff "The pressure ulcer should be assessed/evaluated at least weekly and documented on the Wound RN Assessment UDA. If the resident is on Medicare, document daily on the Wound Data Collection UDA with every treatment change. Observations of the ulcer's characteristics may be documented by a licensed nurse and should include at least the following: "Measurements-length, width, depth; characteristics of the ulcer-including wound bed, undermining and tunneling, exudate, surrounding skin etc; presence of pain' current treatments; Progress toward healing and any modifications to the plan of care/treatments should be assessed and evaluated by the registered nurse."	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329	Sept. 22, 2015	

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F 329	Continued From page 7 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to adequately identify, monitor and assess side effects of psychotropic medications for 3 of 5 residents (R11, R24 and R36) reviewed for psychotropic medication use. Findings include: The facility failed to identify, monitor and assess side effects from psychotropic medications for R11. R11 had a diagnosis according to the admission record dated 12/14/09, of schizophrenia During an observation on 8/12/15, at 9:30 a.m. R11 was drinking diet Dr. Pepper which R11 described as a favorite beverage and the nurse had to get the pop from the medication room at certain times because the staff limited the fluid intake according to R11. Furthermore, R11 explained using a type of cup called a "sippy cup"	F 329	Identification, assessment and monitoring for side effects from psychoactive medications use, specifically antipsychotic medications for R11, R24, and R36 were reviewed. Changes were made to adequately identify, assess and monitor potential psychoactive medications side effects for those residents. The facility will review, and make changes as needed, all resident drug regimens related to antipsychotic medication use to ensure a system is in place to identify, monitor and assess side effects from antipsychotic medication use.	

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F 329	Continued From page 8 to prevent spilling because of the hand shaking/tremors R11 was experiencing. During an interview on 8/12/15, at 9:30 a.m. R11 expressed being thirsty all of the time. When interviewed on 8/13/14, at 10:19 a.m. nursing assistant (NA)-A verified the nurse gave all fluids to R11 because the resident was restricted on fluids because of asking for fluids all of the time. Staff considered R11 asking for fluids all the time as a behavior issue. There was no documentation in the medical record for an accurate intake and output of fluid and there was no correlation of excessive thirst associated with the antipsychotic medication R11 received or the anticholinergic effects of the seizure medication Depakote R11 received daily. A review of the document titled Geriatric Psychiatry Follow Up Appointment dated 3/13/14, and read, "Patient is followed for long history of mental illness of schizophrenia, mental retardation with recent cognitive decline, side effects of psychiatric medications including EPS (extrapyramidal symptoms) of significant UE (upper extremity) tremors, history of unsteady gait worsened after fall 2009 and now in wc, (wheel chair) complex medication regimen including high doses of 2 second generation antipsychotic medications, and medication management." Document review of the medication orders listed Zyprexa 10 mg [milligrams] by mouth one time a day in the a.m. [morning] and Zyprexa tablet give 20 mg by mouth one time a day in the p.m. [afternoon and evening hours] related to hallucinations and the start date for Zyprexa was not listed. The form titled Psychiatry Follow up Appointment and dated 3/13/14, indicated the	F 329	The policy and procedure for identifying, monitoring and assessing side effects from antipsychotic medication use was reviewed and changes will be make in procedure as needed. The facility will educate licensed nursed and the Interdisciplinary Team to changes made that ensure adequate identification, monitoring and assessing of side effects from antipsychotic medication use. The IDT and/or designee[s] will monitor, through audits and monthly meetings, the system used for identifying, monitoring and assessing side effects from antipsychotic medication use.	

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F 329	Continued From page 9 current dosing of Zyprexa was a reduction January 30, 2012. There was no side effect monitoring for the use of Zyprexa medication. The Nursing Drug Handbook 2015 edition indicated Zyprexa could cause adverse reactions such as tremor, constipation and thirst, all of which R11 was experiencing. There were no further attempts for dose reduction since 1/30/12, and R11 was receiving 30 mg a day of Zyprexa when the recommended daily dose read, "Safety of dosages greater than 20 mg per day has not been established." R11 received Seroquel Tablet give 600 mg orally at bedtime related to unspecified Schizophrenia and the start date was 9/24/12. The form titled Geriatric Psychiatry Follow up Appointment and dated 3/13/15, indicated the current dosing of Seroquel 600 mg was a decrease from 800 mg po (orally) qhs (every hour of sleep) from March 9, 2012. One of the reference tools the facility uses for medications, The Nursing Drug Handbook 2015 listed potential adverse reaction to Seroquel as dry mouth and constipation. The indication for Seroquel was to manage signs and symptoms of psychotic disorders. According to R11's plan of care, the only behavior indicated was requests for excessive amounts of liquid but there was no quantifying data to support this behavior. During an interview with the director of nursing (DON) on 8/13/15, at 11:12 a.m. the DON explained that the facility practice was to monitor for drug side effects by exception. There was not an individual system to identify side effects for each resident's antipsychotic medication use and the expectation was for the nurses to use the drug handbooks to look up the side effects or to	F 329	The facility will review audit reports at the monthly QAPI meetings to ensure ongoing compliance. The DNS and/or designee[s] will be responsible for overall monitoring. The DNS is responsible for overall compliance.	

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F 329	Continued From page 10 call the pharmacy if they noticed an exception. During an interview with licensed practical nurse (LPN)-A, who worked full time on 11/13/15, at 11:30 a.m., verified there was not a system for knowing the specific side effects to watch for each individual resident medication and verified the nurse would need to look up the specific side effects in the drug hand book. R24's record did not have documentation of consistent side effect monitoring for psychotropic medication use. Record review revealed an Order Summary Report showing physician's orders for mirtazapine (an antidepressant) 30 mg. at bedtime for depression, quetiapine (an antipsychotic) 20 mg. every day for dementia with delirium, venlafaxine (an antidepressant) 75 mg. two times daily for depression, and trazodone (an antidepressant) 100 mg at bedtime for depression. The medication administration record for August 2015 showed that the resident received all these medications. No documentation of consistent side effective monitoring for these medications could be found in the resident's record. When interviewed on 8/13/15, at 10:46 a.m., registered nurse (RN)-B was asked how side effect monitoring for these medications would be done, and she replied that side effect monitoring for psychoactive medications would be documented by exception in progress notes. She went on to explain that there was a medication reference book available at the nursing station for nurses to look up possible side effects of medications.	F 329		

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F 329	Continued From page 11 R36 did not receive side effect monitoring for psychotropic medication use. R36's undated Admission Record indicated R36 was admitted to the facility on 11/6/2014, with diagnoses including major depressive disorder, dementia with behavioral disturbance, delusional disorder and paralysis agitans. The electronic physician ' s orders indicated R36 was started on hospice care on 5/9/15, R36 took: - Lorazepam (antianxiety) 1 milligram (mg) three times a day and every four hours as needed for anxiety; - Seroquel (antipsychotic) 50 mg twice daily (for dementia with behavioral disturbance) and every 4 hours as needed (for anxiety or behavior per hospice); - Zyprexa (antipsychotic) 2.5 mg daily for dementia with behavioral disturbance; On 8/12/15, R36 was observed from 7:19 a.m. through 10:30 a.m., did not display any behaviors. When attempted to interview on 8/12/15, at 8:30 a.m., R32 did not answer interview questions. R36's significant change Minimum Data Set (MDS) dated 5/18/15, indicated R36 took antipsychotic and antianxiety medications. The Care Area Worksheet dated 5/21/15, indicated R36 had daily echolalia (mimicking other peoples words) episodes, had high anxiety with calling out when needed something, did not like to be left alone (calling out when walked away from her), took medications including Zyprexa, Seroquel, and Ativan, and nursing managed all	F 329		

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F 329	Continued From page 12 R36's medications and observed for adverse consequences. The care plan dated revised on 6/25/15, indicated R36 had impaired cognition and dementia with psychotropic drug use. However the care plan did not direct staff to monitor effectiveness and/or side effects of the medications. The medical record lacked evidence resident specific side effects of the Lorazepam, Seroquel or Zyprexa were monitored. When interviewed on 8/12/15, at 2:09 p.m. the registered nurse (RN)-A, also assistant director of nursing [ADON] stated the facility staff monitored and documented side effects of the medications by exception. RN-A stated there were no resident specific side effects for antipsychotic medication use identified and monitored. RN-A further explained they relied on nurses knowing the side effects of the medications and if they had questions they were expected to refer to the drug hand book. The registered nurse (RN)- B (nurse working regularly with resident) was interviewed on 8/13/15, at 10:04 a.m. and stated for Lorazepam, Seroquel and Zyprexa she would monitor side effects such as: somnolence, over sedation and drug reaction such as itching. RN-C stated she would have to look in the drug book to identify the other listed side effects.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed	F 428		Sept 22, 2015

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F 428	Continued From page 13 pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility's consulting pharmacist did not advise the facility of irregularities regarding the lack of specific side effects monitoring related to the use of an antipsychotic medication for 3 of 5 residents (R11, R24 and R36) reviewed for unnecessary medications. Findings include: Review of R11's medical record revealed a physician order dated, 12/10/11, for Seroquel Tablet, Give 600 mg [milligrams] orally at bedtime related to unspecified schizophrenia, and an order dated 6/11/15 for Zyprexa tablet give 10 mg by mouth one time a day related to Hallucinations and Zyprexa tablet give 20 mg by mouth one time a day related to hallucinations. The plan of care for R11 read, "The resident has a behavior symptom R/T (related to) resident has depression, anxiety, schizophrenia, hx (history) of hallucinations E/B (examples by) refusing to walk or participate in therapies, hx of manipulation, requests for excessive amounts of fluids." An intervention listed; "Nursing monitor for side effects of psychotropic medications. Another	F 428	Antipsychotic medication use be R11, R24 and R36 was reviewed by the Consulting Pharmacist and irregularities in the side effecting monitoring of those medications were identified. Recommendations were made for monitoring specific side effects from those mediations. The recommendations were implemented immediately. The Consulting Pharmacist reviewed all residents using antipsychotic medications and recommendations were made for side effect monitoring of the antipsychotic medications being used.	

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	245285	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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F 428	Continued From page 14 intervention read; Requests for excessive amounts of liquids Behavior #1." There were no details of this behavior listed or assessed as an anticholinergic response to the medications received. During a telephone interview on 8/13/15, at 1:00 p.m. the facility's consulting pharmacist was asked if specific side effect monitoring was expected and reviewed with the use of psychoactive medications when reviewing resident records. The consulting pharmacist verified the facility staff were expected to monitor for side effects with the use of psychotropic medications, but currently the facility did not have a system for individual specific side effect monitoring. A review of the facility procedure dated 9/2012, titled, Medication Regimen Review, directed the Medication Regimen Review will identify the following: -selection of medications based on assessing relative benefits and risks to the resident -evaluation of a resident's signs and symptoms in order to identify the underlying causes including adverse consequences of medications -selection and use of medications in doses and for the duration appropriate to each resident's clinical condition, age and underlying causes of symptoms -monitoring of medications for efficacy and clinically significant adverse consequences -potential medication irregularities and response to these irregularities medication-related errors Furthermore, the Medication Regimen Review procedure read, "In addition, those residents who DO USE these types of medications will receive gradual dose reductions or behavioral	F 428	The policy and procedure for Pharmaceutical Services was reviewed. The facility will re-educate all licensed staff and the Consulting Pharmacist on the policy and procedure for Pharmaceutical Services. The Consulting Pharmacist will continue to review, on a monthly basis, all residents using antipsychotic medications and will report any potential irregularities of side effect monitoring to the Director of Nursing and attending physician at that time. The Consulting Pharmacist will continue to meet with Director of Nursing and/or designee monthly to discuss the Consulting Pharmacist's drug regimen review.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 15 interventions, unless clinically contraindicated, in an effort to discontinue the drugs. The consultant pharmacist failed to identify R24's record did not have documentation of consistent side effect monitoring for psychotropic medication use. Record review revealed an Order Summary Report showing physician's orders for mirtazapine (an antidepressant) 30 mg. at bedtime for depression, quetiapine (an antipsychotic) 20 mg. every day for dementia with delirium, venlafaxine (an antidepressant) 75 mg. two times daily for depression, and trazodone (an antidepressant) 100 mg at bedtime for depression. The medication administration record for August 2015 showed that the resident received all these medications. No documentation of consistent side effective monitoring for these medications could be found in the resident's record. When interviewed on 8/13/15, at 10:46 a.m., registered nurse (RN)-B was asked how side effect monitoring for these medications would be done, and she replied that side effect monitoring for psychoactive medications would be documented by exception in progress notes. She went on to explain that there was a medication reference book available at the nursing station for nurses to look up possible side effects of medications. The consultant pharmacist did not identify the lack of side effect monitoring for R36, who took multiple antipsychotic mediations. R36's undated Admission Record indicated R36	F 428	The facility will review results at the monthly QAPI meetings to ensure ongoing compliance. The DNS, SDC and/or designee[s] will be responsible for overall monitoring. The DNS is responsible for overall compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 16 was admitted to the facility on 11/6/2014, with diagnoses including major depressive disorder, dementia with behavioral disturbance, delusional disorder and paralysis agitans. The electronic physician's orders indicated R36 was started on hospice care on 5/9/15, R36 took: - Lorazepam (antianxiety) 1 milligram (mg) three times a day and every four hours as needed for anxiety; - Seroquel (antipsychotic) 50 mg twice daily (for dementia with behavioral disturbance) and every 4 hours as needed (for anxiety or behavior per hospice); - Zyprexa (antipsychotic) 2.5 mg daily for dementia with behavioral disturbance; On 8/12/15, R36 was observed from 7:19 a.m. through 10:30 a.m., did not display any behaviors. When attempted to interview on 8/12/15, at 8:30 a.m., R32 did not answer interview questions. R36's significant change Minimum Data Set (MDS) dated 5/18/15, indicated R36 took antipsychotic and antianxiety medications. The Care Area Worksheet dated 5/21/15, indicated R36 had daily echolalia (mimicking other peoples words) episodes, had high anxiety with calling out when needed something, did not like to be left alone (calling out when walked away from her), took medications including Zyprexa, Seroquel, and Ativan, and nursing managed all R36's medications and observed for adverse consequences. The care plan dated revised on 6/25/15, indicated R36 had impaired cognition, dementia with psychotropic drug use, and however the care plan did not direct staff to monitor effectiveness and/or	F 428		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 17 side effects of the medications. The medical record lacked evidence resident specific side effects of the Lorazepam, Seroquel or Zyprexa were monitored. When interviewed on 8/12/15, at 2:09 p.m. the registered nurse (RN)-A, also assitant director of nursing stated the facility staff monitored and documented side effects of the medications by exception. RN-A stated there were no resident specific side effects for antipsychotic medication use identified and monitored. RN-A further explained they relied on nurses knowing the side effects of the medications and if they had questions they were expected to refer to the drug hand book. The Medication Regimen Review indicated the pharmacist reviewed R36's mediations monthly (on 12/22/14, 1/26/15, 2/19/15, 3/24/15, 4/27/15, 5/29/15, 6/30/15 and 7/20/15), however did not identify the lack of side effect monitoring. When interviewed on 8/13/15, at 11:08 a.m. the director of nursing (DON) stated she had the expectation of the pharmacist that "if there was regulatory requirement for antipsychotic medication side effect monitoring, he would help identify the lack of it". The consultant pharmacist (CP) was interviewed on 8/13/15, at 11:32 a.m. via phone call, and stated staff should monitor side effects of the antipsychotic mediations, and he was "not sure" if he identified a problem regarding lack of side effects monitoring for R36's Lorazepam, Zyprexa, and Seroquel.	F 428		Sept 22, 2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5285023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/12/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE	**1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on August 12, 2015. At the time of this survey, Good Samaritan Society - Inver Grove Heights was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Good Samaritan Society - Inver Grove Heights, is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1981 and 1983, additions were constructed to the North Wing that was determined to be of Type II(111) construction. In 1999 an addition was added to the South Wing that was determined to be of Type II (111) construction. Because the original building and the 3 additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 44 at the time of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.